DOCUMENT RESUME

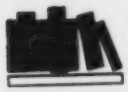
ED 391 303 EC 304 552

AUTHOR	Brown, Wesley; And Others
TITLE	Early Intervention for Young Children at Risk for Emotional/Behavioral Disorders: Implications for Policy and Practice. From the Mini-Library Series on Emotional/Behavioral Disorders.
INSTITUTION	Council for Children with Behavioral Disorders.
REPORT NO	ISBN-0-86586-267-2
PUB DATE	96
NOTE	41p.; For other related documents in this series, see EC 304 550-556.
AVAILABLE FROM	Council for Children with Behavioral Disorders, 1920 Association Dr., Reston, VA 22091-1589 (Stock No. D5132, $11.40, nonmembers, $8 members; $72 set, nonmembers, $50.40 set, members).
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Agency Cooperation; *Behavior Disorders; Cooperative Planning; *Cooperative Programs; Demonstration Programs; Early Childhood Education; *Early Intervention; *Educational Policy; Educational Practices; Educational Trends; Eligibility; *Emotional Disturbances; Evaluation Methods; *Family School Relationship; Inclusive Schools; Individualized Programs; Parent Participation; Policy Formation; Prevention; School Community Relationship; Technical Assistance

ABSTRACT

This monograph is intended to encourage policy formation and appropriate interventions for young children with emotional/behavioral disorders (E/BD). After an introductory chapter, the second chapter analyzes policy within the areas of both behavioral disorders and early intervention, including existing labels and eligibility criteria, reluctance to deal with the category of "serious emotional disturbance," the movement toward increased inclusion and diversity, the status of the medical model, and curriculum advancements. The third chapter discusses current assessment and intervention strategies and trends, including prevention and early intervention, family-centered practices, specialized personnel, and differentiated interventions. The fourth chapter presents a model technical assistance program which stresses the importance of home-school-community collaborative planning efforts. It also identifies trends in intervention approaches including classroom-based intervention, parent training and family-based programs, technical assistance teams, and the design of proactive interventions. A concluding chapter stresses the importance of expanding and developing research and model programs which are effective in identifying young children with E/BD and preventing and/or ameliorating further behavioral disabilities. (Contains 80 references.) (DB)

ED 391 303



From the Mini-Library Series on
Emotional/Behavioral Disorders

Early Intervention for Young Children At Risk for Emotional/ Behavioral Disorders: Implications for Policy and Practice

Wesley Brown
Claudeen A. Conroy
[illegible] Fox
[illegible] University
[illegible] Wesley
[illegible]
[illegible] Lynn Odell
Mary McEvoy
University of Minnesota

Published by
The Council for Children
with Behavioral Disorders

1996

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

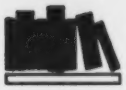
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

R. B. Rutherford, Jr.

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE



From the Mini-Library Series on
Emotional/Behavioral Disorders

Early Intervention for Young Children at Risk for Emotional/ Behavioral Disorders: Implications for Policy and Practice

Wesley Brown
Maureen A. Conroy
James J. Fox
East Tennessee State University
Joseph Wehby
Vanderbilt University
Carol Davis
Mary McEvoy
University of Minnesota

Council for Children with Behavioral Disorders

Published by
The Council for Children
with Behavioral Disorders

1996

About the Council for Children with Behavioral Disorders

CCBD is an international professional organization committed to promoting and facilitating the education and general welfare of children/youth with behavioral and emotional disorders. CCBD, whose members include educators, parents, mental health personnel, and a variety of other professionals, actively pursues quality educational services and program alternatives for persons with behavioral disorders, advocates for the needs of such children and youth, emphasizes research and professional growth as vehicles for better understanding behavioral disorders, and provides professional support for persons who are involved with and serve children and youth with behavioral disorders.

In advocating for the professionals in the field of behavioral disorders, CCBD (a division of The Council for Exceptional Children) endorses the Standards for Professional Practice and Code of Ethics adopted by the Delegate Assembly of The Council for Exceptional Children in 1983.

About This Monograph

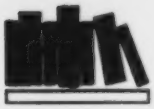
Preparation of this manuscript was supported in part by Grant # H024P100017 from the U.S. Department of Education and the Center for Early Childhood Learning and Development at East Tennessee State University.

Stock No. D5132, ISBN 0-86586-267-2

Copyright © 1996 by The Council for Children with Behavioral Disorders, a Division of The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 22091-1589.

Printed in the United States of America

10 9 8 7 6 5 4 3 2



About the Mini-Library Series on Emotional/Behavioral Disorders

Foreword

Today, professionals are struggling to discover ways to deal successfully with a heterogeneous population of students, some of whom are especially difficult to manage and instruct. No other group of youngsters poses a greater challenge than those variously labelled "seriously emotionally disturbed," "behaviorally disordered," or "emotionally/behaviorally disordered." These children and youth manifest a combination of social, academic, and behavior problems that require not only powerful individual strategies but also effective program options. Fortunately, there is a growing body of knowledge regarding what constitutes quality practices for students with emotional/behavioral disorders (E/BD).

This mini-library series targets the most crucial issues and concerns regarding these children and youth. It covers the needs of students of various ages who are being served in different programs and settings and who demand diverse policy considerations. The mini-library derives from the 1995 international conference sponsored by the Council for Children with Behavioral Disorders. The seven monographs and their authors are

- *Best Practices for Managing the Behavior of Adolescents with Emotional/Behavioral Disorders Within the School Environment*
  Beverley H. Johns, Eleanor C. Guetzloe, Mitchell Yell, Brenda Scheuermann, Jo Webber, Valerie G. Carr, and Carl R. Smith
- *Developing a System of Care: Interagency Collaboration for Students with Emotional/Behavioral Disorders*
  Russell J. Skiba, Lewis Polsgrove, and Karen Nasstrom
- *Early Intervention for Young Children At Risk for Emotional/Behavioral Disorders: Implications for Policy and Practice*
  Wesley Brown, Maureen A. Conroy, James J. Fox, Joseph Wehby, Carol Davis, and Mary McEvoy
- *Effective Strategies for Teaching Appropriate Behaviors to Children With Emotional/Behavioral Disorders*
  Robert B. Rutherford, Jr., Mary M. Quinn, and Sarup R. Mathur

- *Planning and Implementing Effective Programs for School-Aged Children and Youth with Emotional/Behavioral Disorders Within Inclusive Schools*
  Howard S. Muscott, Daniel P. Morgan, and Nancy B. Meadows
- *Teacher-Mediated Behavior Management Strategies for Children With Emotional/Behavioral Disorders*
  Sarup R. Mathur, Mary M. Quinn, Robert B. Rutherford, Jr.
- *Types of Youth Aggression and Violence and Implications for Prevention and Treatment*
  Richard Van Acker

As editors, we strove to bring together information with practical value to the teachers, administrators, and other professionals who must respond to the challenges posed by children and youth with E/BD. We hope this mini-library series will contribute to your success and the success of the students with whom you work.

Lyndal M. Bullock
University of North Texas

Robert A. Gable
Old Dominion University

Series Editors

6

Contents

Foreword iii

1. Introduction 1

2. National Policy Areas 3
Existing Labels and Eligibility Criteria 3
Reluctance and Shifts from the Label "Serious Emotional Disturbance" 5
Toward Inclusion and Diversity 6
Medical Model Status 6
Curriculum Advancements 7

3. Implications for Future Policy Development 9
Prevention and Early Intervention 9
Family-Centered Practices 9
Specialized Personnel 10
Differentiated Interventions 10
Summary 11

4. Implications for Practice 12
General Trends in Intervention Approaches 13
Classroom-Based Intervention 16
Parent Training and Family-Based Programs 19
Technical Assistance Teams: Providing District-Wide Consultation 22
Designing Proactive Interventions 25

5. Conclusion 29

6. References 30

1 Introduction

In spite of the efforts of professionals and professional organizations advocating in the area of emotional/behavioral disorders (E/BD), the past 25 years, in many ways, have been years of lost or missed opportunities. This is especially true when young children are considered. Even at mid-decade in the 1990s, the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (Osher, Osher, & Smith, 1994; U.S. Department of Education, 1994) appears to lack any significant attention to E/BD in young children. Instead, the National Agenda (U.S. Department of Education, 1994) prioritizes issues more specifically related to school-age children and emphasize such areas as drop-out prevention, truancy, and juvenile delinquency.

In addition to the lack of policy attention addressing the needs of young children with E/BD, the field of behavioral disorders has been constrained by the existing *serious emotional disturbance* (SED) label and definition. Attention has been too limited to adequately address individuals who are *at risk* for E/BD or who are being served under a noncategorical label. This is most apparent with young children who are almost exclusively served in noncategorical placements, an option which has vastly increased in the past few years.

Since the 1986 amendments to what is now known as the Individuals with Disabilities Education Act (IDEA), the typical entry point to special education has been effectively lowered from age four to age one. At the same time, adjustments in thinking within the field of E/BD appear to have lagged behind that downward extension. What is the relationship of the behavioral disorder (BD) community with the early intervention (EI) community? How do behavioral disorders fit within the expansion of early intervention? What are the implications for interventions with young children with E/BD? First, we discuss these topics by analyzing policy within the areas of both behavioral disorders and early intervention. Next, current assessment and intervention strategies and trends will be discussed, including classroom and parent-training interventions.

Finally, a model technical assistance program will be presented. The importance of home-school-community collaborative planning efforts will be highlighted throughout. This monograph is intended to encourage communication and action within those communities that will influence how and where appropriate interventions are provided for young children with E/BD.

2 National Policy Areas

Existing Labels and Eligibility Criteria

Those responsible for crafting P.L. 94-142 (1975) and its regulations drew upon the work of Eli Bower and others, work already nearly 20 years old, to cast the terminology and criteria for the label "serious emotional disturbance" (SED). An additional 20 years later, this same terminology and criteria seem unresponsive for today's changing times. Bower's (1981) work predated not only developments in early childhood special education and early intervention but also the entire field of learning disabilities. Particularly, Bower (1981) did not address the unique characteristics of young children beginning to demonstrate inappropriate behaviors which may lead to emotional/behavioral disabilities and the ways these characteristics manifest themselves in young children.

We believe there are several major issues regarding the appropriateness of the federal policy in identifying and serving young children who demonstrate or who are at risk for emotional/behavioral disorders (E/BD). For example, one criterion in the federal definition for identifying a student as "seriously emotionally disturbed" includes measures of academic achievement. We believe that this may be inappropriate for identifying young children with E/BD. Because young children typically do not have a measure of "educational performance," a more appropriate measure would need to be used (e.g., developmental performance).

Another criterion in the federal definition states that the student's behavioral characteristics must be displayed "over a long period of time" and "to a marked degree." Often, the results are that students demonstrating inappropriate behaviors are not labeled SED until the second or third grade. Because preschool age children are just beginning their education, it may be difficult and sometimes inappropriate to measure the persistence of inappropriate behaviors over an extended period of time. This may result in delaying the time until a child is eligible to receive special education or preventative services. For example, a preschooler demonstrating aggressive and noncompliant behavior in a

preschool setting may need immediate intervention to ameliorate the behavior problems that exist and/or to prevent further behavior problems. Because the behaviors this child is demonstrating may not meet the criteria outlined in the federal definition (i.e., academic deficit, problem behavior over an extended time period), the child may not receive services unless he or she is identified and labeled even though some intervention is clearly needed. The question arises, then, about how to identify and appropriately label young children. In this case, the existing definition and criteria would be unresponsive to a preschooler needing immediate attention.

In addition to concerns regarding the current federal definition, there are also weaknesses within the early intervention field for addressing E/BD in young children. Although P.L. 99-457, the Education of the Handicapped Amendments of 1986, addresses the identification of young children with developmental disabilities in a more noncategorical manner than P.L. 94-142, this legislation does not adequately address the provision of services to young children who are at risk for or beginning to demonstrate E/BD. P.L. 99-457 does include social skill deficits as one area in which preschool-age children may be eligible for services. However, there are relatively few valid and reliable measures that can be used to accurately identify E/BD in young children.

Only recently have professionals within the behavioral disorders community begun to develop reliable and valid measures for identifying preschoolers with behavioral disorders (e.g., see Achenbach, 1992). These newly developed assessment instruments typically have been developed as "downward" extensions of school-age versions of similar instruments. For example, the National Center for Clinical Infant Programs (1994) has developed a manual entitled *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. This begins to address the identification of E/BD in young children with primary diagnoses including "traumatic stress disorder," "anxiety disorder," "mood disorder," "adjustment disorder," and the like. Again, this manual appears to be a downward extension of criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV* (DSM-IV; American Psychiatric Association, 1994). Finally, there appears to be little evidence that early intervention programs are incorporating these recently developed instruments. Few early intervention programs, therapeutic preschools, Head Start centers, and other programs are using these instruments to screen and/or identify preschoolers who have E/BD.

In addition, literature within the early intervention and the behavioral disorders communities rarely addresses the particular identification of young children who are at risk for or who have E/BD. Professional organizations such as the Council for Exceptional Children's Division of Early Childhood (DEC) and Council for Children with Behavioral Disorders (CCBD) are just beginning to address the issue of young children with behavioral disorders (e.g., see *Behavioral Disorders*, 1993, 19[1]).

Reluctance and Shifts from the Label "Serious Emotional Disturbance"

It is our belief that the intractability of the existing SED label has created reluctance to deal with this categorical area and contributed to student population shifts from SED and the behavior disorders community. For example, nearly all of the early advocacy and intervention research in the area of autism originated from the behavioral disorders community. The shift of the label "autism" to the category "other health impaired" demonstrates this clear reluctance to and inappropriateness of the SED label. Similarly, attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), which never fit under SED, are listed with "other health impaired," and advocates may soon succeed in creating an independent category.

Another example of a shift from behavioral disorders is the public school implementation of "alternative schools" for students who demonstrate behavioral difficulties. While serving these students in general education programs appears desirable, the service delivery system typically is segregated non-special-education, a form of exclusion which denies the rights afforded to students who are labeled as SED.

Finally, the current movement is to noncategorical labels. As discussed previously, the term SED is not appropriate for the identification of young children with E/BD. Although there are exceptions, the focus of the research and practice within the behavioral disorders community is on techniques that address the needs of E/BD in school-aged children and youth. There has been relatively little effort to change the SED label and criteria to encourage including the preschool/primary age population. Too few members of the behavioral disorders community are actively pursuing techniques for appropriately identifying and labeling young children with E/BD nor are they advocating for changes in the SED label to include preschoolers.

Toward Inclusion and Diversity

Inclusion and diversity represent distinct policy shifts within education and early intervention. While the behavioral disorders community has had a long tradition of being sensitive to issues of diversity, more sensitivity is needed in regard to young children with E/BD and their families. However this is increasingly difficult to achieve within segregated, categorical placements. Miller and colleagues (1993) found a high correlation between current and future placements. The limited functional relationship between the behavioral disorders and early intervention communities has compounded issues of placement and intervention, leaving behavioral disorders influence out of most early intervention settings.

In examining barriers to inclusion, Smith and Rose (1991) found curricular issues to be a minor factor in the exclusion of young children with disabilities (26%). Most often, policies (59%) and attitudes (58%) served as the predominant barriers. Few preschool programs for students without disabilities are structured toward serving young children with emotional/behavioral problems. Preschool classrooms typically use a developmental approach to curriculum—as opposed to a behavioral approach, which is more commonly used to teach children with E/BD. Also, early childhood educators generally do not have the expertise or have not received specific training to work with students with emotional/behavioral problems. Accordingly, these teachers lack the skills needed to address students with challenging behaviors, particularly if the behaviors are severe (e.g., aggression). The general lack of a policy to include young children with E/BD along with teachers' lack of skills often prevent these children from being served in inclusive settings with children without disabilities. For example, one of the strongest federal early childhood initiatives is the Head Start program. Although Head Start's policy is to include youngsters with disabilities, these centers rarely serve young children with serious E/BD. Instead, they usually are referred to mental health centers or public school systems which exclude them from inclusive settings.

It would seem safe to conclude that a strong alliance between the behavioral disorders and early intervention communities could provide better advocacy for young children with E/BD and help facilitate dismantling of the current barriers to inclusive practices.

Medical Model Status

The evolution (or lack thereof) of a medical model for young children with E/BD is an important policy area for examination. We have already

raised categorical and labeling issues. How appropriate are the current *DSM IV* labels for preschoolers? Programs involving hospitalization and therapeutic nurseries continue to utilize treatments consistent with the medical model and which are dependent on Medicaid, CHAMPUS, and other insurance support. How will health care reform impact where high levels of hospitalization exist for students with E/BD? How will changes in insurance policies influence treatment approaches? What has been and will be the influence of the behavioral disorders community on these service delivery approaches?

The medical model is only one approach to providing services for children with E/BD. Other ways to serve them that have been used within the educational community are based on ecological and behavioral perspectives. These approaches should be coordinated and integrated into existing programs to provide comprehensive services for young children with E/BD. For example, are medications increasingly being used in the treatment of children with E/BD? In a nearby school district, a 4-year-old child who was physically aggressive toward his peers recently was placed on medication to reduce his aggression. Although the medication initially reduced his aggressive behavior, other inappropriate behaviors began to appear. A treatment program that relies on a combination (e.g., medical, ecological, and/or behavioral) as opposed to a single approach (i.e., medical) might produce more long-lasting results. We believe there needs to be a coordinated effort between the mental health, medical, and educational communities to better address the delivery of services to young children with E/BD.

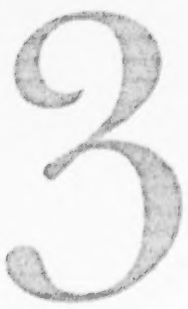
Curriculum Advancements

The current curriculum trends in the behavioral disorders and early intervention communities differ significantly. Within the behavioral disorders community, there have been considerable advances in the area of social skills interventions. Although a number of professionals are discussing social skills interventions for young children (for a review, see Odom, McConnell, & McEvoy, 1991), the literature reflects a primary focus on school-age children with behavioral disorders (e.g., see Goldstein, Sprafkin, Gershaw, & Klein, 1980; Walker et al., 1983).

The curriculum trend in the early intervention literature is to focus on providing *developmentally appropriate practices* (i.e., DAP) for young children with disabilities. Although the use of these practices is evidenced in many early intervention classrooms, they may not always be the most appropriate curriculum approach for young children with E/BD. Often the challenges posed by these children demand a highly structured,

teacher-directed approach that emphasizes manipulation of specific antecedent and consequent events to help ameliorate inappropriate behavior and to teach children appropriate, replacement behaviors. This structured curriculum is in direct contrast to the more child-directed developmental approach.

Implications for Future Policy Development



As outlined in the previous chapter, the national policy trends in the fields of behavioral disorders and early intervention appear to be moving in different directions. This is unfortunate. We believe there needs to be a collaborative effort between the behavioral disorders and early intervention communities to further develop policies for identifying and serving young children with emotional/behavioral disorders (E/BD), in the most appropriate settings and through the most appropriate methods. The following are several venues for collaborative efforts on which professionals in each area could focus their attention.

1. Prevention and Early Intervention

There is a need to identify young children who may be at risk for or who demonstrate E/BD and to provide early intervention that will prevent further disabilities and/or ameliorate existing behavioral disabilities. Because the existing labels and eligibility criteria are insensitive to identifying young children with E/BD, policy needs to be developed to address a range of issues, including (a) which types of diagnostic criteria would be most appropriate for young children who demonstrate E/BD, (b) which types of assessment instruments are appropriate for identification, and (c) to what extent and time period inappropriate behaviors should be measured prior to intervention.

2. Family-Centered Practices

The trend in both the behavioral disorders and early intervention communities is toward services for young children that are family centered. As Brown, Pearl, and Carrasco (1991) assert, family-centered care is a philosophy that stresses the pivotal role of the child's family in his or her development. In this philosophy, the process begins with the professional's viewpoint first being "child-focused," then becoming "parent/child focused," proceeding to "family-focused," and finally, becom-

ing "family-centered." Family-centered services need to be a critical element of intervention for young children with E/BD because many of these children begin to develop inappropriate behavior patterns at home. As outlined in national policy, there needs to be collaborative planning between home and school to serve children with E/BD (U.S. Department of Education, 1994).

Traditionally, the behavioral disorders community has been "family-focused" as opposed to "family-centered." That is, it has suggested that collaborative efforts should be developed between home and school; however, few programs have truly embedded the family in the child's intervention procedures. Policy should be developed that addresses the unique needs of families who have children with E/BD, especially young children. Several model programs have developed "parent intervention" techniques for families who have a young child with behavior problems (e.g., see Timm, 1988). Typically, these programs have focused on teaching parents techniques for dealing with their child's inappropriate behaviors. These programs should be reviewed, and policy should be developed to expand family-centered interventions.

3. Specialized Personnel

Within both the behavioral disorders and early intervention communities, there has been little emphasis on personnel preparation training in the area of preschoolers with E/BD. However, many preschool teachers have difficulty dealing with behavior problems in young children. Further training and preparation in areas such as assessing behavior problems, designing environmental manipulations, and implementing proactive interventions should be given to teachers working with young children with emotional/behavioral problems.

4. Differentiated Interventions

As mentioned earlier, there are two different trends toward intervention in the fields of behavioral disorders and early intervention. In the behavioral disorders community, the trend is to provide services in structured, teacher-directed programs that may restrict the student from placement in a general education setting. In contrast, in the early intervention community the trend is to provide services for preschoolers with disabilities in programs with students without disabilities which generally are more child directed and less structured. In light of these differences, collaboration is needed between the behavioral disorders and early intervention communities to determine the most appropriate placements and intervention for serving young children with E/BD.

Summary

In this chapter, several issues and policies have been examined to promote further professional dialogue regarding the critical issue of preschoolers with E/BD. Although there are significant policy issues to be addressed, practitioners have been providing services for these young children. In the next section, we discuss some of the major trends in intervention and instructional techniques that have been used in practice.

Implications for Practice

The design and implementation of effective interventions for children at risk for developing emotional/behavioral disorders has been identified as one of the most important areas of research in early childhood education (Kazdin, 1985, 1987). Emotional/behavioral disorders (E/BD) are determined by a multitude of factors (e.g., parenting deficits, poor social skills, academic failure). In recent years, it has been determined that assessment of a few key determinants (i.e., school readiness, early display of problem behavior) helps to identify those children who are most at risk for being labeled at an early age as E/BD or who may later engage in problem behavior (Conduct Problems Research Group, 1992; Walker et al., 1988). The development of assessment instruments for the early identification of elementary school-age children has resulted in the field focusing on interventions designed to ameliorate the problem behavior that is often displayed by young children with E/BD.

As noted by Kazdin (1987), identifying effective strategies for children with E/BD is difficult because these children often exhibit a broad array of behaviors (e.g., aggression, hyperactivity, social withdrawal). As a result, multifaceted treatment packages need to be developed that address problems in both home and classroom settings. Unfortunately, most of the work in this area has only partially addressed the needs of these children. That is, family interventions do not usually address problems related to the classroom, while classroom-based interventions often do not include parents during training and implementation (Webster-Stratton, 1993). There are few examples in the literature and fewer intervention programs that effectively address both the classroom-based and family-based problems that characterize these young children.

In this chapter, we review best practices in both of these areas, school and home. First, we note some of the trends in educational and intervention practices that transcend these two major settings. Next, we address specific practices and then offer some exemplary models of intervention programs for young children with or at risk for E/BD.

General Trends in Intervention Approaches

1. Development and Downward Extension of Assessment Technology

Assessment and intervention are intimately linked in a real-world, practical sense. The absence of a coherent technology for accurately identifying and assessing E/BD in children has been a continuing problem for special educators. Although there is no single "litmus test" for identifying E/BD, the assessment technology for school-aged children has improved over the last 30 years. Perhaps one of the most notable, recent accomplishments has been the development of so-called "multiple gating" procedures, as exemplified in the *Systematic Screening for Behavioral Disorders* (SSBD; Walker & Severson, 1992). This instrument is a coordinated series of teacher rankings, ratings, and brief observational samples of school-age children's academic and social behavior, under typical classroom conditions (e.g., seatwork, recess). The *SSBD* effectively and efficiently identifies students suspected of having internalizing (e.g., withdrawal, depression) or externalizing (e.g., aggression, noncompliance) behavioral disorders. Within the last 2 years the *SSBD* and similar procedures have begun to be adapted for use with preschool-aged children (Feil & Becker, 1993; Sinclair, Del'Homme, & Gonzalez, 1993).

While the *SSBD* for preschoolers and the downward extension of other behavior rating scales hold promise, these are relatively recent developments in the area of assessment. Furthermore, the *SSBD* in particular is a screening device for use by school/preschool personnel; by itself, it is insufficient for identifying young children as having E/BD. It would seem appropriate to develop other instruments (checklists, rating scales, structured interviews) through which parents and other caregivers could, in conjunction with the *SSBD*, contribute to the identification process. For example, the Parent Report Form of the Child Behavior Checklist (Achenbach, 1986) might be adapted for use with the *SSBD*. Finally, as we argued in an earlier section, instrument development alone does not address the fundamental flaws in the current federal definition of seriously emotionally disturbed.

2. Factors Influencing Emotional/Behavioral Disorders and Selecting Interventions

Backed by a wealth of applied research, some of it conducted with young children, behavioral procedures have long been the intervention of choice both for eliminating children's behavior problems and for teaching more

appropriate behavior. These include such varied procedures as differential attention ("catch the child being good"), token economies, planned ignoring, time out (sit and watch, time-out ribbons), positive practice, and restitutional overcorrection.

Despite the initial effectiveness of these intervention practices, there have been two related problems in their use. First, there are difficulties in ensuring that young children's positive behavior changes transfer from one situation to another and persist over time, after the intervention has been discontinued. Second, and related to the first, practitioners generally have not selected an intervention procedure based upon the function or motivation behind the child's behavior.

To remedy these deficiencies, researchers and practitioners alike have begun the development and use of *functional assessment and analysis* procedures (Fox & Conroy, 1994; Lennox & Miltenberger, 1989; O'Neill, Horner, Albin, Storey, & Sprague, 1990; Sasso & Reimers, 1988). These functional analysis procedures include the *Motivation Assessment Scale* (Durand & Crimmins, 1988), a teacher-implemented rating scale; analog probes (i.e., a kind of behavioral "allergy test" in which the child is tested under carefully controlled, clinic-like conditions for his or her response to classroom situations suspected of causing the behavior problem); and interview scales that may be administered to the teacher and/or parents to identify the function of the behavior.

Despite their differences, these functional assessment procedures attempt to identify the specific classroom antecedents and consequences that set the occasion for and reinforce behavior problems. Once the motivating conditions are known, then interventions can be tailored to that specific cause. For example, some young children may have a temper tantrum to escape a task; others, to obtain attention. Knowing that a child's disruptive behavior occurs to escape or avoid tasks that are too easy ("boring") or too difficult (aversive) would result in certain intervention prescriptions. That is, the task may be changed to be more appropriate to the child's skill and learning needs; shorter periods of difficult tasks may be interspersed with easier, more enjoyable activities. Other typical behavioral procedures (i.e., isolation timeout), probably would not be indicated because it would play into the child's motivation by temporarily allowing him or her to escape the situation.

These functional assessment procedures initially were developed for use with older adolescents and adults with severe developmental disabilities. Only recently have they begun to be applied to younger children with E/BD. It remains to be seen how well these assessment procedures

and the interventions derived from them will work with young children whose primary difficulty is behavioral. It may be that young children's behaviors and their environmental conditions are too rapidly changing for these techniques to accurately detect stable functional relationships that would lead to prescriptive interventions.

Closely related to functional assessment is *ecological analysis* (Carta, Atwater, Schwartz, & Miller, 1990), a tactic increasingly applied to young children with E/BD and other disabilities. This approach assesses different classroom contexts in terms of the behavior expected or necessary in certain situations. The child's typical behavior is described and compared to the situational expectations. Following this procedure, it is possible to identify discrepancies between a child's current skills and the situational demands, selecting the discrepant behaviors for individualized, positive skill-building programs. This approach already has led to the identification of what have been termed critical "survival skills" for preschoolers as well as for youngsters making the transition to kindergarten and early elementary grades (Beckoff & Bender, 1989; Chandler, 1992; Conroy & Fox, 1993; Downing, Simpson, & Myles, 1989; Murphy & Vincent, 1989). Examples of these skills include task persistence, attention, compliance, and social interaction behaviors, (see Conroy & Fox, 1993, for a review).

3. Naturalistic Teaching and Intervention Contexts

A third trend in interventions that relates to young children with E/BD is the development and application of naturalistic teaching and intervention contexts. There is increasing use of tactics referred to as "natural" or incidental teaching procedures which have their roots in language intervention strategies but can be applied to other behavioral domains. This approach involves identifying typical times or situations in which behavior problems are likely to occur, identifying an appropriate alternative and functionally equivalent behavior, and arranging a brief period of instruction between the teacher and student (or student and peer) to teach the alternative behavior using natural cues and materials. For example, children with or at risk for E/BD often exhibit oppositional behaviors. Many programs designed to teach compliance involve highly structured and/or massed trial training (e.g., Englemann & Colvin, 1983; Forehand & MacMahon, 1981). Such procedures often are necessary for extremely intractable problem behaviors. However, by judicious selection of naturally occurring compliance opportunities throughout the school day, the careful sequencing of teacher requests (Davis, Brady, Williams, & Hamilton, 1992; Mace et al., 1988), and the identification of naturally occurring, child-selected reinforcers, it is pos-

sible to effectively and efficiently teach and motivate children's cooperation with adults.

Another "naturalistic" trend has focused on the social and physical aspects of the settings in which young children are taught. As indicated earlier, there is increasing emphasis on the integration of young children with or at risk for E/BD in classrooms with their typically developing peers. Beyond the legal imperative to serve students in the *least restrictive environment* (LRE), inclusionary programming can have positive benefits on the behavioral development of young children with disabilities, when combined with appropriate materials, environmental arrangements, and teaching procedures. These benefits are particularly applicable in the case of social skills training of young children with E/BD (McEvoy & Odom, 1987; Odom & McEvoy, 1988).

Classroom-Based Intervention

From studies on school-based interventions, we have identified three general strategies that have been used within educational environments to treat young children with E/BD: (a) environmental arrangement, (b) academic or skill tutoring, and (c) social-emotional interventions. The following is a brief overview of each of these interventions.

1. Environmental Arrangement

Educators long have advocated the use of structured environments to promote appropriate social and academic behavior in classrooms (e.g., Haring & Phillips, 1962; Hewett, 1968; Shores & Haubrich, 1969). Aspects of structured environments at the elementary-school level have included posted rules, schedule of events, physical arrangement of equipment, teaching materials, and teacher/pupil ratios. The principles behind these environmental-arrangement approaches can also be applied to preschool environments. Recently, McEvoy, Fox, and Rosenberg (1991) outlined strategies for designing preschool environments that promote competent academic and social responses. Among their recommendations was structuring the physical arrangement of the room. Based on available research, McEvoy et al. (1991) suggested that preschool classrooms be divided into well-defined areas. For instance, a teacher should have specified areas for large-group, small-group, and independent activities. These areas, defined by some physical aspect of the room (e.g., bookshelves, carpet squares), should be used only for their designated activity so that expectations for child behavior are clearly understood for each activity type. Within each of these areas, the curriculum should be designed to promote child engagement and appropriate so-

cial interaction and to decrease opportunities for children to engage in inappropriate behavior.

A second aspect of environmentally sound classrooms is a set schedule of activities. It is important that the class schedule be posted and include information about where the activity is to occur, who is involved in the activity, and how long the activity will last. Having a consistent, predictable schedule eliminates extended periods of time of no active programming. Young children with E/BD often have difficulty dealing with a lack of structure and these "dead times" are prime opportunities for children to display inappropriate behaviors. In addition to consistency, schedules should reflect the developmental level of the child. For young children, the day should be broken into short time segments and alternate between highly arousing activities (e.g., free play) and those less likely to excite the child (e.g., story time).

It is important to underscore that these accommodations to educational environments should not occur in isolation. Rather, each of these components contributes to the overall design of a sound classroom setting. In addition, it is important that changes in the physical environment should be made in the context of good teaching practices, such as proximity control, positive reinforcement (i.e., praise) for appropriate behavior, and consistent, planned consequences for inappropriate behavior.

2. Academic-Related Behaviors and Survival-Skill Instruction

An essential part of any school-based intervention is an intense focus on the academic-related behaviors or skill deficits that often characterize children with E/BD. Academic failure may contribute to the development of problem behavior, and interventions focused on improving social behavior do not necessarily result in improved academic achievement. As a result, comprehensive interventions for addressing the needs of young children with E/BD must include an academic component. For some young children, preacademic interventions may require remedial work in a particular skill needed to be successful in school (e.g., task management, on-task behavior, compliance). In addition, teachers may need to focus on preacademic skills such as letter or numeral recognition as well as the skills necessary for successful interacting with peers and teachers (i.e., sharing, initiating, and responding to others) or receiving instruction (e.g., activity engagement, following directions or rules, working independently, self-help skills).

There are several ways to provide remedial help in these areas. Individual tutoring, by a peer or an adult, can be utilized to promote academic competence. Coie and Krehbiel (1984) found that academic tutoring in low-achieving children resulted in improvements—both academically and socially. Other cooperative learning strategies such as classwide peer tutoring (Greenwood, Terry, Utley, & Montagna, 1993; Kamps, Barbetta, Leonard, & Delquadri, 1994) might also be implemented. Indeed, the deliberate and extensive use of peer-based interventions has been suggested as a preventative measure for dealing with the behavioral disorders of young children (Strayhorn, Strain, & Walker, 1993). It is important that areas of deficiency be identified as early as possible and remediated by whatever means to avoid more serious difficulties in later grades.

3. Social-Emotional Development

Problems interacting with peers are the major feature of children with E/BD (McMahon & Wells, 1989). These children may lack the important social-behavioral skills to interact competently with other children. In addition to these behavioral deficits, young children identified as at risk for developing E/BD may have difficulty in problem solving and may be delayed in their ability to regulate their emotional behavior. Thus, from the perspective of intervention in this domain, behavioral deficits, emotional development, and problem solving may need to be addressed to successfully remediate these skills.

Webster-Stratton (1993) reviewed a variety of classroom-based programs designed for children with E/BD. In the area of social-emotional development, programs focused mainly on either the remediation of skill deficits (i.e., social skills training) or on more cognitive-emotional processes (e.g., problem solving and empathy training). Thus, when evaluating interventions to be used in classrooms, educators should look for approaches that address both the behavioral and emotional factors essential to socially competent behavior.

Many skill-training packages address the social and emotional needs of children who exhibit deficits in these areas (e.g., see Rutherford, Chipman, DiGangi, & Anderson, 1992; Walker et al., 1988). These packages share several common features. In most cases, teachers provide instruction on a particular skill area, provide opportunity for children to practice skills through role-playing, give feedback on children's performance, and reward children for displaying the appropriate behaviors (Webster-Stratton, 1993).

Although these tactics appear successful in providing short-term change in children's social and emotional behavior, the long-term outcomes are largely unknown (Kazdin, 1987). In order to maximize the benefits of social and emotional skill training, most experts recommend that teachers identify those behaviors most important to the child's success in school environments and build skill-training programs to address those needs. It is of particular importance that teachers identify the skills necessary for the successful transition of children to later grade placements. As noted by McEvoy et al. (1991), teachers should take into account the different expectations that children will be facing in other educational environments.

Summary of School Interventions

The three areas reviewed represent the major areas that need to be addressed when developing classroom-based interventions for young children with E/BD. These areas have implications at several different levels. When addressing the needs of children at risk for developing behavior problems, teachers should plan to integrate both the academic and social needs of these children into the daily curriculum. Even the teacher who successfully creates an optimal learning environment for a young child with E/BD may still not be successful in meeting all of that child's needs. As Webster-Stratton (1993) point out, the most effective programs are those that maintain an active partnership between parents and schools. What follows is a review of the successful components of parent training programs.

Parent Training and Family-Based Programs

Parent and family-based interventions for children with or at risk for E/BD are diverse in purpose, content, and format. It is beyond the scope of this review to provide a comprehensive description of all such interventions. They include those designed to impart information about children's behavioral disorders and resources for dealing with them; programs designed to teach parents teaching and behavior-management skills; groups to provide social support for family members; and additional services to assist parents in coping with other family, financial, or social-community problems that influence and are influenced by the child's behavior problems.

As with classroom-based interventions, behavioral procedures have a well established history in the family-based treatment of young children with E/BD. Over the last 35 years, studies have repeatedly shown that

parents and siblings can learn both general behavioral principles and specific intervention tactics. When applied, these tactics can effectively eliminate mild to severe behavior problems—aggression, opposition, self-injury, stereotypy—and increase adaptive behaviors—positive interaction with family members or friends, cooperation, language, and self-help skills (see for example, Fox & Savelle, 1987; Kaiser & Fox, 1985).

From this research base, a number of behavioral parent-training packages and curricula have emerged. Some materials are written for a more general audience, for example, *Parents are Teachers* (Becker, 1971), and *Families* (Patterson, 1975), while others focus on particular situations such as children with attention deficit hyperactivity disorder (Barkley, 1987), autism (Kozloff, 1973) or young children with developmental disabilities who also exhibit behavior problems (Baker et al., 1989). Many are designed to be self-instructional.

Despite the documented effectiveness of the individual procedures and the comprehensive packages (e.g., Kaiser & Fox, 1985), there is increasing recognition that family-based interventions, particularly those for young children with E/BD, may require more systemic analysis if not intervention. In line with the distinctions made in the first section of this monograph, interventions need to move from being family based (i.e., interventions for child behavior mediated by family members) to more family centered (i.e., interventions which address the varied needs of families of children with E/BD). In general, families of children with disabilities often experience a number of environmental stresses, some originating within the family itself and others from outside (e.g., Gallagher, Beckman, & Cross, 1983), and these stresses tend to increase with the severity of the disability. Families of children with E/BD are at increased risk for such stresses. For example, as a group, families of children with severe behavioral disorders, (e.g., autism) report restricted opportunities for the leisure and social activities that most families consider important and desirable (Koegel, Schriebman, Britten, Burke, & O'Neill, 1982).

In the case of children with conduct disorders, the evidence shows that they typically are part of a family system wherein most or all family members mutually engage in negative or "coercive" interactions with one another. In such cases, effective interventions are ones that, rather than simply focusing on the child's negative behaviors, produce reductions in all family members' negative interactional exchanges (Patterson, 1982). There is also mounting recognition that for a certain proportion of these families events beyond the nuclear family affect the problem-

atic patterns of interaction within the family. For example, over the last 20 years evidence has emerged showing that some parents of young children with conduct disorders—especially those living in high crime or poverty areas—are subject to a specific but complex form of social stressor known as *insularity*. This term refers to the lack of regular friendship interactions and a disproportionate number of negative interactions with relatives and community helping agencies (e.g., Wahler, 1980). This insularity has been linked to increased levels of parent-child coercive interactions and significant problems in producing lasting improvements in family interaction patterns (e.g., Wahler, 1980).

Model programs for young children with or at risk for E/BD have several characteristics:

- They effectively address the familial as well as the educational needs of the child.
- They produce concrete improvements in the child's development and behavior in preschool/school, at home, and in the community.
- They accomplish these outcomes through tested intervention tactics that are implemented in a coordinated, collaborative manner by the child's teachers, parents, peers, and siblings.

One well-established early intervention program for young children with E/BD is the Regional Intervention Program (RIP; for an expanded description see Timm, 1993). First established in Nashville, Tennessee, in 1969, RIP now has sites across the United States and several other countries. RIP represents a unique collaboration between parents and professionals to provide both a developmentally enhancing preschool experience for the children and intervention for the participating families. Through a carefully sequenced set of direct training activities, parents learn to view the interdependent nature of their child's behavior problems and the responses of family members. Training involves learning to observe and analyze their child's behavior, applications of specific behavior management and skill teaching procedures, and techniques for generalizing and maintaining improved developmental and social behavior skills. This training is accomplished through various structured modules, along with practical experience in the project's preschool program. Rather than simply being recipients of training, parents become active trainers and program staff members, serving as teachers in the preschool and as trainers of other parents who are just entering the program. The short- and long-term effectiveness of the program has been documented in a series of program evaluations (Timm, 1988).

RIP is not the only program that has successfully sought to provide exemplary services to young children with E/BD and their families. Indeed, there are a number of programs serving young children with autism that employ many of the school and family-based components of the RIP model and which are described in detail in a recent compendium by Harris and Handleman (1994). Though they vary in specific programmatic characteristics (i.e., curricula, particular services, staffing configurations, and training arrangements), each contains a mix of naturalistic and structured teaching tactics, use of functional assessment and intervention strategies to deal with behavior challenges, functional skills assessment and training, parent training and participation, and other collaborative interactions to support positive child development through home-school collaboration.

In all, research and empirically based practices for children with E/BD have had a comparatively short history (Morris & Kratochwill, 1983). However, since the establishment of the first child guidance clinic at the turn of the last century until the present, there have been significant advances in both assessment and intervention for these children. More recently, attention has begun to focus on young children who are at risk for or demonstrate E/BD. In this section, we detailed some of the intervention advances and trends. Now, we consider how these school and home programs can be strengthened through ongoing technical assistance and other community-based efforts.

Technical Assistance Teams: Providing District-Wide Consultation

Throughout America, there is a strong push to provide inclusive preschool education to young children with disabilities. A number of authors have enumerated the benefits to children both with and without disabilities when they have chances to play and learn together (Odom & McEvoy, 1990; Turnbull, 1982). Unfortunately, many children with E/BD often are denied opportunities to participate in inclusive programs. Teachers and related service personnel alike have difficulty dealing with the challenging behaviors that these children present. In fact, teachers have reported that these challenging behaviors represent the major reason that some children are educated in segregated settings (Kerr & Nelson, 1989).

Typically, the staff of service delivery programs have relied on outside consultants to work with teachers to design effective interventions for children with E/BD. Usually, this consultation includes a combination

of inservice training and direct consultation about a specific behavior problem. Wolfe (1993) and Reichle (1990) have identified a number of problems inherent in this consultant model:

- Consultants generally are "called in" when a behavior problem is at the crisis level. This often creates a situation where reactive interventions are implemented. While immediately effective, these interventions often do not include procedures either for teaching positive replacement behaviors or for fading the intervention over time.
- In many situations, consultation and inservice training do not include ongoing feedback or evaluation. Because of the lack of follow-up, intervention implementation issues or the possible need for changes in intervention are not addressed.
- When consultants are hired on a case-by-case basis, there is no provision for system-wide training.

Based on these and other problems associated with short-term inservice training, there is a growing consensus that longitudinal, on-site technical assistance is a critical and necessary component of effective consultation (Bailey, 1989; Fredericks & Templeman, 1990). In fact, Campbell (1990) has suggested that quality consultation results in

1. Delineation of specific training needs.
2. Incentives for personnel to participate.
3. Clear identification of expected outcomes.
4. Supervised application of information with ongoing feedback.

Recently, through a federally funded project, we have been assisting local districts in the design and evaluation of interventions to help children who are at risk for E/BD or who otherwise demonstrate challenging behaviors. Through the Minnesota Behavioral Support Project (McEvoy & Reichle, 1991), we have developed a system for training school personnel to deliver technical assistance to teachers and others. In designing this Technical Assistance Model, we decided to develop procedures for training teams employed by a service delivery program to design, assist with implementation, and evaluate interventions. Building into a program the capacity to handle the needs of teachers and others is crucial. In fact, the school districts and programs with whom we have worked have noted that they have saved on outside consultant fees by initially investing funds to train their own team of consultants.

In setting up a Technical Assistance Team, it is important to select team members who

- Represent multiple disciplines. Typically, our teams have included early childhood special education teachers, early childhood education teachers, school psychologists, related service professionals, parents, paraprofessionals, and speech/language pathologists.
- Have extensive experience working with young children with and without challenging behaviors.
- Have experience as a member of a team.
- Have a respect for objective data-based instruction and decision making.
- Are willing to learn.
- Have time to devote to the task. For example, each team member devotes approximately 5 to 6 hours per week to team activities. The team usually meets for about 2 to 3 hours per week. During this time, the team discusses specific challenging behaviors and generates a list of possible interventions. Team members spend the remaining 3 hours per week working independently on referrals. That is, a team member might interview parents or teachers about a specific child's behavior or observe the child in his or her home or school setting.

Once the team is selected, it is important that the team receive training on how to provide technical assistance. Through our project, we have developed a series of interactive training modules to assist with this training. Basically, training is divided into two basic areas: how to assess challenging behavior and how to design appropriate proactive interventions.

Assessing Challenging Behaviors

We suggest that teachers use a number of different ways to assess problem behavior. For example, it is important to interview the adults who know the child with challenging behaviors. Parents and teachers should be asked such questions as: What does the challenging behavior look like? When is it likely to occur? Where does the behavior occur most often? What happens when the child engages in the behavior? Why do you think the child exhibits this behavior? Researchers have conducted extensive studies that substantiate the worth of assessing the antecedents (what happens before the child engages in the behavior) and consequences (what happens after the behavior occurs) that control problem behaviors (Carr & Durand, 1985; Iwata, Dorsey, Slifer, Bauman, & Richman, 1982; O'Neill, Horner, Albin, Storey, & Sprague, 1990). By

identifying the antecedents and consequences that maintain the problem behavior, teachers, parents, and others are better able to develop consistent interventions that take into account these important variables.

For example,

- Mr. Smith notices that Terry tends to scream and hit others after he is asked to do something that apparently he does not like to do. Terry may be engaging in the challenging behavior (screaming and hitting) to get out of an unpleasant task; that is, Terry is likely to engage in problem behavior to escape having to perform the task requested.
- Susan screams and hits whenever she wants to get the teacher to help her. She has learned that this challenging behavior gets her immediate teacher attention. In this instance, we would say that Susan's behavior is attention motivated.

As discussed earlier, Durand and Crimmins (1988) have developed the *Motivational Assessment Scale (MAS)* that is filled out by teachers, parents, and others. This instrument helps identify the antecedents and consequences (i.e., attention or escape) that might be maintaining a child's challenging the behavior. Information obtained through the interviews is confirmed through direct observation. The team member spends time in the classroom or the home, observing the child and recording each instance of challenging behavior. Using an adapted Functional Analysis Form (O'Neill et al., 1990), team members are asked to note when the challenging behavior occurs and the antecedents and consequences of the behavior. Based on this information, we develop a hypothesis about the possible function of the behavior. These data are then used to design proactive, antecedent-based interventions.

Designing Proactive Interventions

Will (1984) noted that children with behavior problems, to a great extent, are not benefiting maximally from their educational placements. In part, this may be because teachers and other service providers often rely on reactive intervention strategies (Guess, 1990; Mace & Shea, 1990). These reactive interventions are implemented after the challenging behavior has occurred. They might include time-out, overcorrection, or response cost. However, in the last decade, national organizations such as the Division of Early Childhood (DEC), the Council for Children with Behavioral Disorders (CCBD), and the Association of Persons with Severe Disabilities (TASH) have developed position statements calling

for proactive, antecedent-based intervention strategies for addressing problem behaviors. Such interventions, unlike reactive interventions, are implemented prior to the occurrence of problem behaviors.

1. Preferred Item or Activity as a Distracter

In our project, we have evaluated a number of proactive interventions. One of the least intrusive interventions utilized in classrooms with young children has been termed *preferred item or activity as a distracter* (McEvoy & Reichle, 1991). With this strategy, the teacher or parent uses a preferred item or activity to distract the child from engaging in problem behavior. For example, Scott darts out of the classroom every time he is asked to wait for a few seconds before transitioning to a new activity. His mother has noted that he likes to color with crayons. Using this information, the teacher allows Scott to color between activities in order to keep him involved in something that he prefers while transitions are occurring.

2. Prespecifying Reinforcers

There is an old adage that children are likely to do something that they do not necessarily want to do if they know that they will get to do something that they like later. In first applying this concept, the teacher identifies times or activities in which challenging behaviors are most likely to occur. Prior to beginning the activity, the teacher lets the child pick a desired reinforcer (e.g., 5 minutes at the art center; reading a book) and then tells the child "if you remain in the group activity for 5 minutes you can go play in the art center." The child is likely to remain in an unpreferred activity if she knows that access to something she likes will occur very soon.

3. Choice-Making

A growing number of studies have examined the effects of allowing children to make choices as a form of intervention. Only recently, however, has choice-making been validated as an intervention effective in decreasing problem behaviors in young children who exhibit behavioral problems (Dunlap et al., 1994). For example, Kathleen typically hits other children when she is asked to help clean up after snack. The teacher decides one day to give Kathleen a choice of cleaning activities. Kathleen is told, "You can throw away the napkins or you can wash the table." What professionals have noticed is that when given a choice of two generally unpreferred activities, one becomes preferred and typically elicits a positive response. It is important to note that Kathleen is given the

choice prior to exhibiting hitting because the teacher knows that cleanup is a time at which hitting typically occurs.

4. Collaboration

Collaboration is an intervention in which the child and another individual work collaboratively to finish a task that has been identified as problematic. Joe may have a difficult time completing an instructional activity, for example, matching sample food items to picture cards. This difficult activity increases the probability that Joe will engage in challenging behavior. Joe's speech pathologist might offer to help him finish the activity by saying, "If you will match two items, I will match two items."

5. Tolerance for Delay in Reinforcement

This intervention is effective when trying to teach children to tolerate a delay in receiving reinforcement. Tolerance for delay can be used to teach children to wait for (a) items or attention requested by the child, (b) tangibles promised for reinforcement, and/or (c) release from an undesired task. This intervention includes delivering a *delay cue* immediately prior to the child engaging in challenging behavior. A delay cue is a verbal or gestural cue letting the child know that he or she is about to receive reinforcement. For example, when Nick is denied access to items that he has requested such as a puzzle or lotto cards, he begins to hit and scream at the individuals standing near him. When Nick requests a puzzle, the teacher delivers a delay cue saying, "Hold on, Nick." The teacher then waits a few seconds before giving the puzzle to Nick. Systematically, the time between the delay cue and the child receiving the desired item is increased, thus teaching the child to wait for the reinforcement.

6. High-Probability Requests

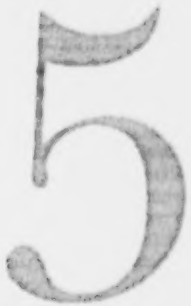
High-probability requests is an intervention that recently has been validated with children with E/BD. This intervention consists of delivering high-probability requests (i.e., a simple set of requests that the child is likely to perform) immediately prior to asking the child to perform a task in which the child typically engages in a problem behavior For example, Karen typically will not comply to the requests to pick up her toys without screaming. Her dad first gives her three simple instructions which he is confident she will follow ("touch the block," "give me five," and "point to the basket") immediately prior to asking her to "pick up the blocks." We have found that giving children instructions

they typically will follow gets them in a "momentum" to comply with a instruction which they would not typically follow.

Summary

Through the Minnesota Behavioral Support Project, we attempted to make school districts more self-sufficient in the delivery of services to young children with behavior problems. We have focused heavily on helping teams organize environments to prevent behavior problems; conduct functional assessments of problem behaviors; design proactive interventions; and work with families and other professionals to address the challenging behaviors of young children. By empowering local districts to address challenging behaviors as they occur, we have increased the number of successful inclusive education opportunities for young children with these behaviors. In addition, measures of consumer satisfaction, teacher/family implementation of intervention, and child behavior change indicate that Technical Assistance Teams are an effective and efficient use of district resources. Given the increasing number of young children who exhibit challenging behaviors, we believe that districts must look beyond one-shot inservice workshops or the use of outside behavior consultations to address the needs of children with E/BD, their families, and the professionals who work with them.

Conclusion



The purpose of this monograph is to promote discussion between professional communities and share information regarding "best practices" for providing services to young children who are at risk for or who demonstrate emotional/behavioral disorders (E/BD). Perhaps one of the most critical issues we discussed relates to the need to continue to develop valid and sensitive techniques for identifying and assessing young children who engage in challenging behaviors and/or who have E/BD. In addition, it is critical to develop curriculum and intervention strategies that promote inclusion of these young children in their natural environment with their peers while addressing their behavioral needs. Another critical area is the development of programs that are family centered—programs that address not only the needs of the child but also the needs of the family as they relate to the child's development and behavior. Even though extensive research has been conducted on evaluating intervention strategies and techniques, there is relatively little discussion of this research within the early intervention community. There is a need for further collaboration and discussion among the professional communities working with these children in order to develop comprehensive programs for them and their families. A part of this collaboration would be preservice and inservice training programs that provide teachers with the necessary skills to meet the needs of these children.

As we described throughout the monograph, researchers and practitioners are developing model programs that are effective in meeting the educational and behavioral needs of these young children. Further expansion and development of these programs should be encouraged to identify these children at an early age and prevent and/or ameliorate further behavioral disabilities.

6

References

Achenbach, T.M. (1986). *The Child Behavior Checklist for Ages 2-3, Parent Report.* Burlington, VT: University Associates in Psychiatry.

Achenbach, T.M. (1992). *Manual for the Child Behavior Checklist/2-3 and 1992 Profile.* Burlington, VT: University of Vermont Department of Psychiatry.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Bailey, D. (1989). Issues and directions for preparing professionals to work with young handicapped children and their families. In J.J. Gallagher, P. Trahonis, & R. Clifford (Eds.), *Policy implementation and P.L. 99-457; Planning for young children with special needs* (pp. 97-132). Baltimore: Paul H. Brookes.

Baker, B.L., Brightman, A.J., Blacher, J.B., Heifetz, L.J., Hinshaw, S.P., & Murphy, D.M. (1989). *Steps to independence* (2nd Ed.). Baltimore, MD: Paul H. Brookes.

Barkley, R.A. (1987). *Defiant children: A clinician's manual for parent training.* New York: Guilford.

Becker, W.C. (1971). *Parents are teachers: A child management program.* Champaign, IL: Research Press.

Beckoff, A.G., & Bender, W.N. (1989). Programming for mainstream kindergarten success in preschool: Teachers' perceptions of necessary prerequisite skills. *Journal of Early Intervention, 13*(3), 269-277.

Bower, E.M. (1981). *Early identification of emotionally handicapped children in school* (3rd ed.). Springfield, IL: Charles C. Thomas.

Brown, W., Pearl, L. F., & Carrasco, N. (1991). Evolving models of family-centered services in neonatal intensive care. *CHC, 20*(1), 50-55.

Campbell, P. (1990). Meeting personnel needs in early intervention. In A. Kaiser & C. McWhorter (Eds.), *Preparing personnel to work with persons with severe disabilities* (pp. 111-134). Baltimore: Paul H. Brookes.

Carr, E., & Durand, V.M. (1985). Reducing behavior problems through functional communication training. *Journal of Applied Behavior Analysis, 18,* 111-126.

Carta, J.J., Atwater, J.B., Schwartz, I.S., & Miller, P.A. (1990). Applications of ecobehavioral analysis to the study of transitions across early education settings. *Education and Treatment of Children, 13,* 298-315.

Chandler, L.K. (1992). Promoting children's social/survival skills as a strategy for transition to mainstreamed kindergarten programs. In S.L. Odom, S.R. McConnell, & M.A. McEvoy (Eds.), *Social competence of young children with disabilities: Issues and strategies for intervention* (pp. 245-276). Baltimore: Paul H. Brookes.

Coie, J.D., & Krehbiel, G. (1984). Effects of academic tutoring on the social status of low-achieving, socially rejected children. *Child Development, 55,* 1465-1478.

Conduct Problems Prevention Research Group. (1992). A developmental and clinical model for the prevention of conduct disorder: The FAST Track Program. *Development and Psychopathology, 4,* 509-527.

Conroy, M.A., & Fox, J.J. (1993, November). *Critical school social and survival skills: Observational analyses of typically developing, behaviorally disordered, and mentally retarded preschoolers.* Paper presented at the 17th Annual Conference of Teacher Educators of Children with Behavioral Disorders, Tempe, AZ.

Davis, C., Brady, M., Williams, R., & Hamilton, R. (1992). Effects of high-probability requests on the acquisition and generalization of responses to requests in young children with behavior disorders. *Journal of Applied Behavior Analysis, 25,* 905-916.

Downing, J.A., Simpson, R.L., & Myles, B.S. (1989). Regular and special educator perceptions of nonacademic skills needed by mainstreamed students with behavioral disorders and learning disabilities. *Behavioral Disorders, 15*(4), 217-226.

Dunlap, G., dePerczel, M., Clarke, S., Wilson, D., Wright, S., White, R Gomez, A. (1994). Choice-making to promote adaptive behavior for students with emotional and behavioral challenges. *Journal of Applied Behavior Analysis, 27,* 505-518.

Durand, V.M., & Crimmins, D. (1988). *Motivation assessment scale.* Topeka, KS: Monaco & Associates.

Englemann, S., & Colvin, G. (1983). *Generalized compliance training: A direct-instruction program for managing severe behavior problems.* Austin, TX: PRO-ED.

Feil, E.G., & Becker, W.C. (1993). Investigation of a multiple-gated screening system for preschool behavior problems. *Behavioral Disorders, 19,* 44-53.

Forehand, R.L., & McMahon, R.J. (1981). *Helping the noncompliant child: A clinician's guide to parent training.* New York: The Guilford Press.

Fox, J.J., & Conroy, M.A. (November, 1994). *Evaluation of classroom/teacher-implemented methods of assessing factors that motivate young children's behavior problems.* A paper presented at the 18th Annual Conference of Teacher Educators of Children with Behavioral Disorders, Tempe, AZ.

Fox, J., & Savelle, S. (1987). Social interaction research and families of behaviorally disordered children: A critical review and forward look. *Behavioral Disorders, 12,* 276-291.

Fredericks, B., & Templeman, T . (1990). A generic inservice training. In A. Kaiser & C. McWhorter (Eds.), *Preparing personnel to work with persons with severe disabilities* (pp. 111-134). Baltimore: Paul H. Brookes.

Gallagher, J.J., Beckman, P., & Cross, A.H. (1983). Families of handicapped children: Sources of stress and its amelioration. *Exceptional Children, 50,* 10-18.

Goldstein, A.P., Sprafkin, R.P., Gershaw, N.J., & Klein, P. (1980). *Skillstreaming the adolescent: A structured learning approach to teaching prosocial skills.* Champaign, IL: Research Press.

Greenwood, C. R., Terry, B., Utley, C. A., & Montagna, D. (1993). Achievement, placement, and services: Middle school benefits of classwide peer tutoring used at elementary school. *School Psychology Review, 22,* 497-516.

Guess, D. (1990). Transmission of behavior management technologies for researchers to practitioners: A need for professional self-evaluation. In A.C. Repp & N.N. Singh (Eds.), *Perspectives on the use of nonaversive and aversive interventions for persons with developmental disabilities.* Sycamore, IL: Sycamore Publishing.

Haring, N.G., & Phillips, E.L. (1962). *Educating emotionally disturbed children.* New York: McGraw-Hill.

Harris, S.L., & Handleman, J.S. (1994). *Preschool education programs for children with autism.* Austin, TX: PRO-ED.

Hewett, F.M. (1968). *The emotionally disturbed child in the classroom.* Boston: Allyn & Bacon.

Iwata, B., Dorsey, M., Slifer, K., Bauman, K., & Richman, G. (1982). Functional analysis of self-injury. *Analysis and Intervention in Developmental Delays, 2,* 3-20.

Kaiser, A.P., & Fox, J.J. (1985). Behavioral parent training research: Contributions to an ecological analysis of families of handicapped children. In P. Vietze & J. Gallagher (Eds.), *Families of handicapped persons: Current research, treatment, and policy issues* (pp. 219-235). Baltimore: Paul H. Brookes.

Kamps, D. M., Barbetta, P. M., Leonard, B.R., & Delquadri, J. (1994). Classwide peer tutoring: An integration strategy to improve reading skill and promote interactions among students with autism and general education peers. *Journal of Applied Behavior Analysis, 27,* 49-61.

Kauffman, J.M. (1993). *Characteristics of emotional and behavioral disorders of children and youth* (5th ed.). New York: Merrill.

Kazdin, A. E. (1985). *Treatment of antisocial behavior in children and adolescents.* Homewood, IL: Dorsey Press.

Kazdin, A. E. (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin, 102*(8), 187-203.

Kerr, M.M., & Nelson, C.M. (1989). *Strategies for managing behavior in the classroom* (2nd ed.). Columbus, OH: Merrill/MacMillan.

Koegel, R.L., Schreibman, L., Britten, K.R., Burke, J.C., & O'Neill, R.E. (1982). A comparison of parent training to direct child treatment. In R.L. Koegel, A. Rincover, & A.L. Egel (Eds.), *Educating and understanding autistic children* (pp. 260-279). San Diego, CA: College Hill.

Kozloff, M.A. (1973). *Reaching the autistic child: A parent training program.* Champaign, IL: Research Press.

Lennox, D.B., & Miltenberger, R.G. (1989). Conducting a functional assessment of problem behavior in applied settings. *Journal of the Association for Persons with Severe Handicaps, 14,* 304-311.

Locke, P. & Reichle, J. (1990). *Operating procedures for the establishment of an augmentative and alternative communication assistance team.* Unpublished manuscript, University of Minnesota, Minneapolis, MN.

Mace, F.C., Hock, M.L., Lalli, J.S., West, B.J., Belfiore, P., Pinter, E., & Brown, D.K. (1988). Behavioral momentum in the treatment of noncompliance. *Journal of Applied Behavior Analysis, 21,* 123-141.

McEvoy, M. A., Fox, J. J., & Rosenberg, M. S. (1991). Organizing preschool environments: Suggestions for enhancing the development/learning of preschool children with handicaps. *Topics in Early Childhood Special Education, 11*(2), 18-28.

McEvoy, M.A., & Odom, S.L. (1987). Social interaction training for preschool children with behavioral disorders. *Behavioral Disorders, 12,* 242-251.

McEvoy, M., & Reichle, J. (1991). Minnesota Behavioral Support Project. (No. H024P10017). Minneapolis, MN: University of Minnesota.
McMahon, R.J., & Wells., K.C. (1989). Conduct disorders. In E.J. Mash & R.A. Barkley (Eds.), *Treatment of childhood disorders* (pp. 73-134). New York: Guilford.
Miller, L., Strain, P., McKinley, J., Heckathorn, K. & Miller, S. (1993). *Preschool placement decisions: Are they predictors of future placements?* Pittsburgh, PA: Allegheny-Singer Research Institute on Preschool. (ERIC Document Reproduction Services No. ED 360 771).
Morris, R.J., & Kratochwill, T.R. (1983). Introduction and overview. In R.J. Morris and T.R. Kratochwill (Eds.), *The practice of child therapy* (pp. xi-xvii). New York: Pergamon Press.
Murphy, M., & Vincent, L.J. (1989). Identification of critical skills for success in day care. *Journal of Early Intervention, 13*(3), 221-229.
National Center for Clinical Infant Programs. (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood.* Arlington, VA: Author.
Odom, S.L., McConnell, S.R., & McEvoy, M.A. (Eds.). (1991). *Social competence of young children with disabilities: Issues and strategies for intervention.* Baltimore: Paul H. Brookes.
Odom, S.L., & McEvoy, M.A. (1988). Integration of young children with handicaps and normally developing children. In S.L. Odom and M.B. Karnes (Eds.), *Early intervention for infants and children with handicaps* (pp. 241-267). Baltimore: Paul H. Brookes.
Odom, S.L., & McEvoy, M.A. (1990). Mainstreaming at the preschool level: Potential barriers and tasks for the field. *Topics in Early Childhood Special Education, 10*(2), 48-61.
O'Neill, R.E., Horner, R.H., Albin, R.W., Storey, K.S., & Sprague, J. (1990). *Functional analysis of problem behavior.* Pacific Grove, CA: Brooks-Cole.
Osher, D., Osher, T., & Smith, C. (1994). Toward a national perspective in emotional and behavioral disorders: A developmental agenda. *Beyond Behavior, 6*(1), 4-17.
Patterson, G.R. (1975). *Families: Applications of social learning to family life.* Champaign, IL: Research Press.
Patterson, G.R. (1982). *A social learning approach, vol. 3: Coercive family processes.* Eugene, OR: Castalia.
Reichle, J. (1990). Summary report of a working conference on positive approaches to the management of challenging behavior. A conference sponsored by NIDRR, Washington, D.C.
Rutherford, R., Chipman, J., DiGangi, S., & Anderson, K. (1992). *Teaching social skills: A practical instructional approach.* Ann Arbor, MI: Exceptional Innovations.
Sasso, G.M., & Reimers, T.M. (1988). Assessing the functional properties of behavior: Implications and applications for the classroom. *Focus on Autistic Behavior, 3*(5), 1-15.
Shores, R.E., & Haubrich, P.A. (1969). Effects of cubicles in educating emotionally disturbed children. *Exceptional Children, 35*, 21-26.
Sinclair, E., Del'Homme, M., & Gonzalez, M. (1993). Systematic screening for preschool behavioral disorders. *Behavioral Disorders, 18*, 177-188.
Smith, B.J. & Rose, D.F. (1991). *Identifying policy options for preschool mainstreaming. Research Institute on Preschool Mainstreaming.* Allegheny-

Singer Research Institute. (ERIC Document Reproduction Services No. ED 338 403).
Strayhorn, J.M., Strain, P.S., & Walker, H.M. (1993). The case for interaction skills training in the context of tutoring as a preventive mental health intervention in schools. *Behavioral Disorders, 19,* 11-26.
Timm, M.A. (1993). The Regional Intervention Program: Family treatment by family members. *Behavioral Disorders, 19,* 34-43.
Timm, M. (1988). RIP: A parent-implemented treatment model for families of behaviorally disordered and/or developmentally delayed young children. In J. Stark, F. Menolascino, M. Albarelli, & V. Gray (Eds.), *Mental retardation and mental health: Classification, diagnosis, treatment, services* (pp. 281-293). New York: Springer-Verlag.
Turnbull, 1982
U.S. Department of Education. (1994). *The national agenda for achieving better results for children and youth with serious emotional disturbance.* Washington, DC: Chesapeake Institute.
Wahler, R.G. (1980). The insular mother: Her problems in parent-child treatment. *Journal of Applied Behavior Analysis, 13,* 207-219.
Walker, H.M., McConnell, S. Holmes, D., Todis, B., Walker, J., & Golden, N. (1983). *The Walker Social Skills Curriculum: The ACCEPTS Program.* Austin, TX: PRO-ED.
Walker, H.M., & Severson, H.R. (1992). *Systematic Screening for Behavior Disorders (SSBD): A Multiple Gating Procedure.* Longmont, CO: Sopris West.
Walker, H.M., Severson, H., Stiller, B., Williams, G., Haring, N., Shinn, M., & Todis, B. (1988). Systematic screening of pupils in the elementary age range at risk for behavior disorders: Development and trial testing of a multiple gating model. *Remedial and Special Education (RASE) 9,* 8-20 .
Webster-Stratton, C. (1993). Strategies for helping early school-aged children with oppositional defiant and conduct disorders: The importance of home-school partnerships. *School Psychology Review, 22*(3), 437-457.
Wehby, J., Dodge, K., & Valente, E. (1993). School behavior of first grade children identified as at-risk for development of conduct problems. *Behavioral Disorders, 19,* 67-78.
Will, M.C. (1984). Educating children with learning problems: A shared responsibility. *Exceptional Children, 52,* 411-415.
Wolfe, K. (1993). *A survey of preschool educators' priorities for inservice training.* Unpublished manuscript, University of Minnesota, Minneapolis, MN.